STATEMENT OF DENTAL REMUNERATION

SDA Proposal

Contents

Abbreviations 2
The Contract 3
Background 3
The Scottish Patient 4
The PC and Financial Considerations 4
Scottish Dentists 5
Oral Health 5
The Process 6
Language 6
Our Aims 7
Governance 7
Our Proposal 8
Clinical Considerations 10
Summary 12
Document Revisions 13

Abbreviations

AFC	Agenda for Change
BDA	British Dental Association
CDO	Chief Dental Officer
CDS	Community Dental Services
CHI	Community Health Index
DCP	Dental Care Professional
DDRB	The Review Body on Doctors' and Dentists' Remuneration
DMFT	Decayed, missing, filled teeth
FTE	Full Time Equivalent
GDP	General Dental Practitioner
GDPA	General Dental Practice Allowance
GDS	General Dental Services
HB	Health Board
HDS	Hospital Dental Services
IOS	Item of Service
LDC	Local Dental Committee
NHS	National Health Service
NMC	New Model of Care
PC	Patient Contribution
PDS	Public Dental Services
PMPR	Professional Mechanical Plaque Removal
PSPP	Public Sector Pay Policy
SDPC	Scottish Dental Practice Committee
SIMD	Scottish Index of Multiple Deprivation
SG	Scottish Government

The Contract

There is no other healthcare system that compares with dentistry. The term 'contract' is loosely applied, yet the expectations of patients and those in Governance, in terms of GDPs, has risen dramatically since its initial application. The NHS GDS system in Scotland is based upon the 1990 fee per item contract which incurs incentives towards and allegations of overtreatment. Its objective was improving the nation's oral health, but it also created mistrust and demoralised the profession.

The Capitation/Continuing Care element of the contract was intended to allow allocation of 20% Target Average Gross Income (TAGI). The supposition was that this would allow pro rata time for focus on prevention, emergencies, and general care of the patient. The duty of care towards patient's oral health and the almost unquantifiable growth of clinical governance pervading the IOS system and its application, now extends far beyond 20% of a GDP's time. This has resulted in a significant pro bono effect- further exacerbated by the fact that some IOS payments do not actually meet the staff costs.

Background

The NHS GDS is grossly underfunded due to a systemic downgrading of GDP/dental team values through a variety of repeated failings. These include but are not limited to increasing the number of GDPs drawing from the GDS budget (by 17% from 2011-2019, as per stated SG policy); acceptance of the PSPP through Westminster and its predilection towards inflationary increments (7.5% between 2011-2019); SG's poor consideration of DDRB's recommendations on GDP's expenses which increased hugely during the same period; an unwillingness to include or place NHS GDS workers within the pay scales of the AFC (introduced in 2004) through additional expenses awards; a determination to subject GDPs to arbitrary awards with 'no proper negotiations' according to the SDPC, the recognised negotiating arm of the BDA Scotland; the complete absence of any legal representation in discussions with SG.

Effectively, these combined issues have resulted in real terms pay reduction more than 30% for GDPs whilst dental nurses have fallen almost 20% behind those working as employees doing the same job, within the PDS/CDS/HDS.

SG have, for several years, recognised that the SDR is "too complex" and "an obstacle to modern dentistry" for young dentists whilst GDPs stand recently accused of not explaining the system adequately to the patient. There has been no consistent, documented (public) effort by SG to explain the system to the patient at any time since the Scotland Act (1998). There are more than 400 items within the SDR, with the gaps in affordability for the GDP. The SDR now completely precludes the employment of hygienists within the NHS GDS whilst their services might be potentially more affordable than those of GDPs. This and many other aspects of the SDR would seem to be a huge economic oversight for SG. Similarly, there is almost no margin between the laboratory fees for some prostheses and the total payment award for that item within the SDR. We are unaware of any SG engagement with hygienists/dental technicians.

The Scottish Patient

Patients deserve a better quality of treatment from the NHS than that which they currently receive. The lack of bespoke periodontal treatment, for example, is a huge issue for which Secondary Care is ill-equipped. Scottish dental patients are entitled to essential treatments within the SDR, and we are unaware of a formal proposal to significantly reduce this range of entitlement. Patients also, however, demand a level of cosmetic and private treatments from time to time, as is their right and freedom of choice. Scottish citizens retain the right to a private contract. GDPs are obliged to advise their patients appropriately in terms of which treatments they are happy to offer within the NHS. Patients are already suffering financially due to the 1-year delay for many who require routine care, because of the current restriction on patient numbers. To establish an understanding of where we may be heading, it may be useful to consider the 740,000 respondents to the English GP patient survey, pre-COVID-19 from January to March 2020 (NHS England GP Survey Results Summary, 2020; (1).

"25.9% of the respondents who did not try to get an NHS dental appointment in the last two years said they preferred private dentistry, the same number of percentage points compared to the same period last year. Those respondents who stayed with their dentist when they moved from NHS to private made up 11.5%."

Everything points towards a demographic which is moving more quickly than ever, with some of the delays already deemed to be avoidable and impinging on the patient's purse.

The PC and Financial Considerations

The PC is an unwanted component of the payment calculation for any healthcare professional. It represents less than £18 per annum for the average Scottish adult – viewed by many as a significant but until now missed economic opportunity by SG, given the average UK adult spends circa £200 per annum on oral healthcare products. GDPs are unhappy with the allegations of 'money grabbing' whilst they request such minimal sums from their patients and are vastly underpaid when compared to medical practitioners, who have been treated very differently. As a service to any Scottish Government, most GDPs would accept collecting payments which were incidental to their payment awards other than being deducted from HB monies received. Recently SG have pledged to eliminate the PC, worth £76m pa. There has been no consultation regarding public expectations of NHS dentistry or the expectations of the dental team. These may have been relevant to the proposal to offer free dentistry but the underlying message from the current SG seems to be that the best dental system is affordable. This is excellent news for the Scottish patient, the Scottish GDP, and their hard-working staff.

We have long since tired of the IOS ball and chain. COVID-19 has changed the nature of dental practise significantly and permanently. Most of us appreciate the opportunity to spend time discussing treatment options and processes- time which was disavowed by the historic SDR. There will be other pandemics. Dentistry is the profession subjected to the highest risk of contamination with infectious agents, working with bio-aerosols, spatter, and splatter on a sessional basis. It continues to present a challenging working environment, but this has not deterred young people from following a career within dentistry. Indeed, it continues to be the hardest Scottish degree course to access, and Glasgow/Dundee dental schools are currently the hardest of the UK's 16 dental schools for which to meet entry requirements.

The pathway towards GDP status involves 6-7 years of under/postgraduate training, although young pupils/students/VTs have been subjected to an additional year increment because of COVID 19. This will affect over 1,000 young dentists - qualifying the demand for incentivisation. Elevated PPE/ventilation/fallow times will inevitably become common parlance within 'best practice.' Extended appointment times and the patient's rightful demand for a better service will add pressure to a pre-existing melting pot going forward.

Oral Health

During normal surgery hours, GDPs are mainly concerned with the oral health of their patients and its administration. There appears to be no public record or information forthcoming on the nation's periodontal health. This is a major consideration which must be quantifiable prior to NMC engagement. There has been little credit (financial or otherwise) offered to GDPs for improvements to Scotland's oral health as evidenced within Adult Health Surveys. There have, however, been significant claims by SG for such credit within DDRB correspondences. This is despite a system which facilitates little or no time for a GDP allocated towards prevention.

The Oral Health Improvement Plan has been rescinded, having been described by the Mr Tom Ferris CDO recently as "on another planet." Many of its precepts intended to regulate and improve the oral healthcare of the elderly and those in areas of high deprivation. It is believed that there is currently almost no time or appetite for domiciliary attendance within the primary care sector. The number of Scotland's over 75's is expected to rise by 79% in the next 25 years. This is a looming oral health disaster, the prevention and treatment of which will depend first and foremost on GDPs willingness to significantly change their practising habits.

Whilst caries rates have been improved significantly, there continues to be a worrying gap between patients in areas of high deprivation and the rest of the Scottish population. It is increasingly difficult to employ GDPs within these and rural areas.

The Process

The CDO has assured the profession that there will be proper engagement on this process. Currently, the SDPC (a sub-committee of the BDA) are subject to the authority of the Principal Executive Committee in London. A significant majority of GDPs and almost all their employees are not represented by a Union. The SDPC advises that key aspects of negotiations must be totally confidential, that the process does not until now involve the actual act of negotiation and that there has until now been no legal representation at any of the meetings. They are (perhaps consequently) the only body formally recognised by SG.

Language

Dentists were traditionally awarded parity with doctors through DDRB processes and advice to Westminster, until SG recognised that the GP contract required to be amended. We expect parity to be reinstated for GDPs, as it prevails within the CDS/PDS/HDS. NHS employee Dental Nurses are paid within Band 4 of AFC, receiving circa 20% more than NHS GDS Dental Nurses. Contractor GPs in Scotland were paid an average of £101,300 in 2018/19 according to NHS Digital.

To keep pace with earnings from 15 years ago (which they have failed to do), GDPs have been accused of overtreatment and not explaining an incredibly complex system properly to their patients. They may carry out significantly more treatment appointments than GPs, be paid much less for NHS work and work in a continually contaminated environment but the SG language towards medical practitioners is much more favourable. The process of negotiation is not only recognised but honoured regarding the whole profession.

The following is an excerpt from the Scottish Government's document titled (Scottish Goverment, 2017; (2)

"We agree that no GP should receive less than £80,430 (inclusive of pension contribution) for a whole-time post.

From 1 April 2020 we propose to:

- *Introduce an income range that is comparable to that of consultants.*
- *Directly reimburse practice expenses*
- *As these measures would again change GP practice funding and GP income, they will be subject to negotiation and a second poll of the profession after specific details (including financial details) are available.*

Negotiations on this phase will include arrangements for the protection of GP income and practice expenses……. We have agreed that GP income should not be subject to arbitrary variation.

It is intended that these changes will help to reduce GP workload and allow the GP to focus on their role, improve patient outcomes, community health and practice sustainability."

The language of negotiation with Scottish GDPs must therefore change. It must be a proper consultation with the whole dental practice community and should adopt similar recognition and acceptance of widespread problems for Scottish patients and GDPs.

Our Aims

Our principal aim is to create a better and more preventive oral healthcare system for the Scottish patient, which fairly rewards the entire dental practice team. We seek parity with GPs who have been promised that there will be no arbitrary awards going forward. All of Scotland's GDP pay awards since the Scotland Act (1998) have been arbitrary, given the total absence of historic negotiations and all discussions being subject to complete confidentiality. Recently GDPs were awarded 57% of the lowest GP rates for out of hours work on NHS24. There was no "out of hours" increment vis a vis normal SDR values as assessed by the CDO. These statements are evidence that the second-class appraisal of NHS GDPs as healthcare professionals is systemic. We have at no time in Scotland been the subjects of contract negotiation- a shocking admission for our Government.

Separately, we aim to create a more unified approach, through membership at no cost with a £1 liability. We will improve connectivity and support for DCPs. We must also now look forward rigorously to a four-day working week and strive for AFC conditions- at the rightful behest of SG. The NMC must now embrace these as cornerstones. If it is good enough for the NHS, it is good enough for NHS dental practice staff.

Governance

The GDC are the professional regulator of GDPs and DCPs. Local Health Board authorities accept GDPs, providing 'list numbers' as they deem appropriate, carry out practice inspections and monitor GDS provision to their communities. This is also a form of significant regulation. The SG/CDO have no legal authority over Private treatment whether it occurs in wholly Private or 'mixed' NHS/Private dental practices. GDPs are accepting of current levels of Governance and the requirement to fulfil their NHS GDS terms of service. The CDO has alluded to an increase in Governance but it is widely accepted that this will be declined by large numbers of GDPs and their respective patients. GDPs must honour the requirement to provide all NHS/Private treatment options and risks. Further, SG will have no way of policing private referrals between dental practices. The contracts are private.

Our Proposal

This is a serious proposal. It is not comprehensive. In the absence of any transparency within the current arrangements it is always incumbent on any dental committee, group, or association to make known their views. It is surprising that no one has been able to define a suggested reform/make it part of the public debate, given the thirteen-month transitional period since the pandemic outbreak. The manifestation of views on a way forward will be echoed, denied, and accentuated by all forms of media, whether they be social, radio, television or 'press.' The debate should be public.

General Dental Practices are 'rated' by PSD regarding their NHS Commitment financially, as per their percentage of NHS remuneration documented within certified audited accounts. This is not necessarily an accurate reflection of time and as such is merely a starting basis for our proposal. The initial values may well be predicated on the recently accounted monies received since this will be the only certified documentation received by the PSD. Going forward everything will be based upon time, as it should be in the interests of fairness, transparency, and patient equity.

We propose that the said percentage level of commitment is initially undertaken and directly transposed in relation to the accepted time given towards NHS GDS going forward, during normal working hours. This will be redefined as a 0.2/0.4/0.6/0.8/1.0 FTE multiple of £80,430 as a minimum for each GDP. The FTE hours are accepted as 9am-6pm or similar with a one-hour lunchbreak: 40 hours per week or a 'whole time contract.' A working example may be that an 80% NHS Committed practice with 2 full time GDPs may elect to have a 1.0 FTE NHS Associate and a 0.6 FTE NHS principal. The practice contract will be set on the whole-time commitment for example: 8 full days of NHS appointments per week in this instance and the Associate's contract will be set accordingly with the Principal. The payment of FTE remunerative parity with GP is based upon the premise that the individual GDP position is worthy of at least that payment on a pro rata basis.

NHS commitment over recent years has averaged 75% on gross fees. The new NHS bands might be set at 20/40/60/80/100% based upon the levels of choice and the requirement for NHS GDS carried out within the normal working hours as above. Practices which are 100% committed to NHS GDS will retain the right to private treatments on an extra-curricular basis. Local HB authorities may monitor NHS commitment through practice inspections which would inevitably be a more comprehensive undertaking. Segments of the Practice Inspection may be carried out remotely, eg shared NHS Commitment audit, with Clinical aspects inevitably contributing to the NHS Commitment and audited time consideration. Monthly GP forms detailing NHS hours commitment may be submitted to reduce the likelihood of quarterly clawbacks with GDPA- in addition to GP17s monitoring dental activity. This will facilitate a better understanding for SG regarding the values of clinical time, with respect to NHS versus 'private' merits: a 'win win.'

Aside: patients may be required to consent to their notes being accessed by an independent/HB GDP as part of the Practice Inspection audit.

Dental practice expense awards should continue in the form of a new GDPA, not based upon treatment values, which may include the same NHS commitment percentage calculations as applied to reception staff/Dental Nurses (currently Band 4 equivalent £21,892-24,157 with an imminent 4% increment), Dental Hygienists (currently Band 7 equivalent £38,890-44,503) and Practice Managers (currently Band 5 equivalent £25,351-£31,966).

In single handed dental practices, a multiple of 1.0, 1.0 and 0.5 may be applied to the receptionist, dental nurse (both AFC Band 4) and practice manager (AFC Band 5) positions, respectively. All these positions would be subjected to the NHS commitment percentage calculation. There should be additional increments of 0.5, 1.0 and 0.5 respectively for these positions as per each additional FTE GDP.

The principal dentist cannot be precluded from assuming the role of practice manager. Dental practice management is an arduous and complex role, and many GDPs often find the acceptable recruitment for these positions impossible. Implementing and maintaining policy documentation as well as clinical standards/staff management as set within inspection protocols represents a huge commitment which does not vary with NHS commitment. This is a price worth paying, however, in the name of every patient, given there is neither an additional requirement for Health Improvement Scotland inspection nor the requirement for double governance.

Laboratory fees for NHS treatments should be directly recompensed in full- this will improve SG engagement with laboratory technicians, a fundamental cog within the GDS. Materials (with obvious exclusions such as implant related items, Botox/Dermal Fillers, specialist equipment/materials), engineering fees, insurances, equipment purchases (within an agreed scale), utilities, rent and other such items will be subjected to the percentage calculation. An alternative GP expenses form will be created to facilitate monthly expenses claims and submitted alongside the NHS GDS monthly hours audit.

Dental practice expenses may finally be reviewed comprehensively. This will allow SG to reach out, polling the profession in its entirety, in the fashion that they have so promised medical practitioners.

The SDR may preserve most items as they are with no dentist fees attached- only patient fees will remain. Porcelain veneers, bridges and cobalt chrome dentures may be removed.

The focus of the dental team will finally of course be on prevention and treatment of dental/oral diseases. There may be a greater role for dentists in terms of the Oral Health Risk Assessment, smoking cessation, and advice on diet/alcohol consumption.

NHS patients should be entitled to professional mechanical plaque removal, despite questions on the disease merits of this treatment, with intensive oral hygiene instruction and/or monitoring every 3-6 months. It may be difficult to motivate patients in the absence of professional mechanical plaque removal. These treatments may also have a positive impact on self-worth and mental health. In cases of bleeding on probing with pockets of more than 4mm, more extensive periodontal treatment should be carried out as required.

Orthodontic retainers may be added, allowing provision by GDPs, without the requirement for active therapy in the first instance. This may be an approach to anterior overcrowding prevention when all the adult canines and premolars have fully erupted. There may be a review/reduction of orthodontic IOTN qualifying criteria. SG may consider that 20% of the GDS Courses of Treatments represents too high a figure for one specialty/modality classification.

Certain treatments may not necessarily be obligatory. GDPs should never be compelled to provide posterior composites routinely unless the pre-existing qualifying criteria are strictly applied.

The treatment of diseased but non-functional molar teeth should not be obligatory within NHS GDS, unless there is a missing premolar within that quadrant and the space is closed. Similarly, re-treatment of failed root treatment in any molars should not be obligatory- these are just a couple of examples of restrictions which should apply. There should be guidelines on appointment lengths dedicated towards certain NHS dental treatments for example ninety minutes hours for a single root canal tooth, two hours for a multiple root canal tooth. These terms are in the interests of a service which needs to prioritise oral health and reasonable treatment outcomes, whilst gleaning some value for the Scottish taxpayer.

Each practice should be committed to a minimum level of domiciliary care as per the requirements of each HB authority who would be expected to distribute the respective commitments through liaisons with residential care managers. Travel time will be included within these measurements and NHS Commitments. Travel costs will be recompensed accordingly and included within the new GDPA.

It is imperative that the basis for future commitment and fee awards is founded upon the time aspect of percentage calculations. The reason for this is that SG and NHS GDS awards cannot compete or keep pace with the 'private' sector, and this would manifest itself as a race to the bottom for the NHS patient.

An arrangement such as this will also fix a long standing and unacceptable truth, that the private patient's payments underpin the financial inadequacies of the current NHS GDS. This is a situation which is unacceptable to Scottish citizens paying privately. Finally on this point, it is true to say that many patients/dentists have exercised their right to access private dental care. COVID 19 has dramatically changed NHS dental practise. There is no guarantee that the thousands of patients haemorrhaging from NHS practices to private dental care will return. As such, procrastination on a NMC will inevitably expose SG and Scottish patients to reduced levels of NHS care. Many patients feel that the outbreak of COVID thirteen months ago has subjected them to a harshly reduced level of NHS dental care.

GDPs, depending on their circumstances, may welcome the opportunity to 'opt up' or 'opt down' on their pre-COVID NHS commitment for each practice with a minimum band level of 20% equivalent to 8hrs per week per dentist with an NHS list. GDPs will retain the right to choose their profile as independent practitioners in order that SG stems a greater exodus to wholly private practise and an increased emigration of Scottish GDPs.

Audit of Clinical Activity

The most important aspects of providing clinical care to patients is providing evidence-based dentistry and continuously auditing and reviewing our clinical effectiveness.

Audit would be our tool to monitor our effectiveness and allow for rigorous Dental Public Health epidemiological analysis of Scotland.

For audit to be a successful tool we need to establish the scope and criteria. These need to be in synchrony with the clinical activity and need to be clear and efficient. Further consultation with Dental Public Health Experts is required.

For example:

- Patient name, date of birth, address, CHI number
- SIMD
- Risk
    - Caries
        - Sugar
        - Plaque
    - Periodontitis
        - Plaque
        - Diabetes
        - Smoking
        - Genetics
    - Cancer
        - Smoking (pack years)
        - Alcohol (units/week)

- DMFT
    - Decayed, missing, filled teeth
- Treatment per item and tooth
- Treatment time

Summary

The aging Scottish population deserves to be rid of the aging SDR as it serves to undermine their oral health and the grudging participation of the dental profession. This brief document outlines many of the issues, points of ongoing debate and a serious proposal but the process must start immediately with a profession-wide poll on expenses. The delay on this by SG precedes COVID-19 by several years. It is only through the expenses 'window' that SG may forecast their budget in a professional manner, with due consideration of GDP remuneration, staff wages, and PC in that order since the former is contingent on expenses and the latter is contingent on the cumulative cost.

Principal dentists run their practices not only to look after the patients in their community but also as a small business. This is the only method of protecting the job security within their workforce which has evidently been undermined by the SDR, as evidenced so clearly by AFC. The consensus amongst the dental profession is that protracted negotiations will not serve NHS dentistry well.

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